Practical Issues in Working with Dual Diagnosis Patients

‘Real World’ Considerations

Group Membership and Attendance Issues

- Sporadic Attendance patterns
- Stable group of ‘regular customers’, with other groups of occasional visitors and one-time participants
- Patients who are hospitalized or incarcerated
- Even within the context of a single session, group members in and out of the room, arriving late, leaving early
- Bottom line….expect group membership to fluctuate and evolve on a daily, weekly basis, with perhaps only 25% of the group consisting of ‘regular customers’ (and even the ‘regular customers’ turning over every few months)

Implications of Attendance Patterns

- Group cohesiveness suffers as a function of ‘strangers’ who fluctuate in and out of group
- Trust
- Therapist familiarity with Client problems, histories (importance of communication with team members)
- Inability to systematically pursue therapeutic issues
- Balance the need of the regulars to ‘move on’, as opposed to the need of the newcomers to get an introduction and orientation
- Not any easily available solutions to these problems!(typical solution has been to alternate between the needs of old timers and newcomers, enlist the help of the more articulate old timers in explaining concepts to new comers)

General Issues Pertaining to Working with Chronically Mentally Ill Patients in Groups

- Avoiding the 'individual therapy in group' interactional pattern (using eye contact, explicit instruction regarding group process)
- Disruptive behavior
- Clients who are disoriented, tangential, have difficulty focusing
- Despite all of the above….patients still have a remarkable capacity to provide empathy and support

‘Nuts and Bolts’ of Group Sessions’

- Introductory sessions (repeated at periodic intervals depending on group membership)
- Pros and Cons
- Relapse prevention

Introductory Session

- ‘A little bit different way of looking at addictive behavior’
- Brief lecture on the stages of change model (handouts)
- ‘Direct’ group in a subtle manner, by asking questions and engaging in single and double sided reflections (‘help me understand this better)….(‘so correct me if I’m wrong, but it sounds like you’re saying that…’)

Precontemplation

- Begin at the beginning…'What, me worry?
- Having fun, feeling good, social facilitation (not so different from the rest of us)
- Symptom relief
- 'Appreciate your honesty'
- Feeling good (or better) is fast and easy
- Some patients (as well as therapists) have difficulty in acknowledging the 'pros' of substance abuse, especially those who have participated in (and benefited from) aggressive, 'in your face' AA and NA programs

Maintaining a Precontemplative State

- Everyone is doing it! (selection of deviant peer groups and distorted norms)
- I'm not hurting anyone (except myself?)
- I can quit any time I want (reality vs illusion of self control)
- Coping with others who suggest I might have a problem
- I need this to cope
- Any one ever get forced to enter a treatment program while in precontemplation?

Contemplation

- Negative effects (‘pile up’)
- Repeated failure of attempts to control
- Making the connection between negative effects and substance use
- Not really serious about changing, just thinking about changing
- Switching from one substance to another in an effort to regain control
- Acknowledging ambivalence!!!
- If this was easy, would any of us be here?

Determination and Action

- Listing the pros and cons
- So how do you decide to change?…..getting ‘sick and tired’ of being ‘sick and tired’
- Sincere efforts to change
- Periods of sobriety
- Coping Strategies
- Motivational interviewing designed to bring people to this stage, not get them through it

Relapse

- Intending or planning to relapse….relapse as a voluntary, intentional, planned behavior (under voluntary control!!!)
- Lapse vs relapse
- Relapse triggers in the context of the previously discussed balance between the pros and cons
- Harm reduction

What does a successful group look like?

- Substantial cross talk and group process
- Group members freely express feelings of ambivalence, without fear of criticism
- Group members spontaneously engage in ‘change talk’
- Resistance is dealt with via reflection and sharing of experiences, rather than via confrontation and argumentation
- In other words….group members engage in motivational interviewing procedures themselves
- Therapists guide group process via asking questions and making reflections that focus the group’s attention on key issues.

Motivational Interviewing

Preparing clients for change

Background and History

- Prochaska, early 1980s
- Smoking cessation research
- Poor outcomes and levels of participation
- Extension to other addictive behaviors, as well as to more generic counseling/psychotherapy applications

Stages of Change

- Precontemplation
- Contemplation
- Determination/Preparation
- Action
- Maintenance
- Permanent departure
- Relapse

Characteristics of Precontemplators

- What…..me worry?
- Aren't just unmotivated, don't see the problem in the first place
- …so if you offer them a treatment…they will not participate voluntarily
- If required to participate, they 'go through the motions'
- Denial and selective attention
- Blaming others
- Illusion of control
- Peer group norms

Key Issues

- Stages as continua vs categories
- Time spent in the Precontemplation/Contemplation interstice
- Large number of clients in this stage, even among those who present themselves for treatment
- Two ‘primordial stages’; those ready to change vs those not ready
- Moving those who are ‘not ready’ to ‘ready’
- Recurring, central theme in human affairs….delaying short term gratification for long term rewards vs obtaining a ‘quick fix’ and paying for it later
- Pay me now, or pay me later

Motivational Interviewing

- Miller and Rollnick (1991); revision expected out next year
- Wide application to both ‘addictive’ as well as conventional counseling/psychotherapy change issues
- Conceptually, not strictly a ‘therapeutic’ technique

Methods and Procedures (FRAMES)

- Feedback
- Responsibility
- Advice
- Menu
- Empathy
- Self-efficacy
- Not necessarily in this order!

Additional Procedures

- Developing discrepancy and goal setting
- Decisional balance and selective reinforcement
- Reflection (single and double sided)
- Avoiding arguments
- Using summaries
- Being aware that therapist goals and client goals may be very discrepant

Motivational Interviewing and Medication Compliance

- Practical application of MI techniques
- Ambivalence about medication taking
- Side effects and stigma issues vs therapeutic benefits (recurring theme of short/long term costs/benefits)
- Provide information about medication's expected benefits and side effects in an objective, non-evaluative context
- Emphasize patient control and choice as the central aspect of compliance

Medication Compliance, cont.

- be sensitive to expressions of ambivalence; encourage patients to discuss their concerns
- …but at the same time, ask them to recall past costs/benefits, and emphasize benefits
- Focus on a short term 'trial' period as the initial goal….not 'this is a medication you need to take for the rest of your life'
- Express a willingness to work with patients with regard to side effect issues….titrate doses, try alternative medications, etc
- Avoid argumentation….for instance, try not to establish a paradigm of interaction which involves acceptance of diagnostic labels

Medication Compliance, cont.

- On follow-up, ask about side effects and manifest a willingness to talk about measures designed to ameliorate them, but make note of therapeutic benefits and call patients' attention to benefits rather than costs

Chronic Mental Patients with Substance Abuse Disorders

Enhancing Patient Motivation

University of Missouri Medical School

- Professor of Psychiatry and Neurology
- Clinical Psychology
- DMH treatment programs
- University of Missouri Department of Intercollegiate Athletics

A Brief History

- Early 1980s (Bachrach, 1982; Caton, 1981; Pepper et al., 1981)
- lifetime rates in the 40 to 60% range
- comorbidity associated with relapse and rehospitalization, violent behavior, HIV infection, suicidality, homelessness
- extraordinarily 'high cost' patient group due to extensive use of hospitals and emergency room services

Intervention Models: Some Basic Parameters

- Inpatient vs Outpatient
- Group vs Individual
- Brief vs Extended
- Treatment philosophies (eg., abstinence vs controlled drinking)
- Motivational readiness

Review of the Literature

- Drake, et al ; Bellack and Gearon, 1998
- 36 ‘studies’ many of which are very poorly controlled
- early studies involved relatively brief, low intensity interventions and were characterized by extraordinarily high drop out rates

Review of the Literature, cont

- More recent studies have involved much more intensive interventions, integrated within the context of an assertive community outreach model
- client engagement in treatment is relatively high and favorable outcomes in terms of a number of important psychiatric and community adjustment variables are evident

Hellerstein et al. (1995)

- 47 recently discharged patients with schizophrenia and substance abuse
- randomly assigned to integrated vs nonintegrated outpatient services
- within 4 months 38 vs 70% had dropped out of treatment
- within 8 months, so many had dropped out of both treatments that further analysis was not possible

Drake et al, 1997

- 217 patients, many with schizophrenia and all with substance abuse
- integrated intervention with intensive case management vs traditional follow-up

Drake, continued

- Higher levels of involvement in psychotherapy (91% v 58%)
- Higher level of involvement in A&D counseling (76% v 24%)
- less time hospitalized
- better control over substance use

Motivational Interviewing Applied to Dual Diagnosis Patients (Miller and Rollnick, 2ed)

- Increased engagement in (out) patient treatment (Daley et al 1998; Daley and Zuckoff, 1998; Swanson, 1999;Martino et al, 2000)
- Medication adherence (Martino et al, 2000; Kemp et al, 1996,1998)
- Short term Alcohol consumption (Graeber et al, 2000)

Characteristics of Effective Treatment Programs

- Assertive community outreach, intensive case management
- integrated mental health/substance abuse services
- stage based intervention efforts
- you get what you pay for

Stage Based Intervention Programs

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Precontemplaters

- Don’t see their substance use as a problem and thus are unmotivated to seek or accept help
- End up in treatment when only when coerced
- If required to participate in treatment, will ‘go through the motions’
- Will drop out of treatment at the first opportunity and resume substance use

Working with Precontemplaters

- Motivational Interviewing (Miller and Rollnick, 1991)
- express empathy
- develop discrepancy
- avoid argumentation
- roll with resistance
- support self efficacy

Precontemplators, cont.

- F feedback
- R responsibilty
- A advice
- M menu
- E empathy
- S self-efficacy

Chronic Mental Patients who are Precontemplators

- Bellack and Gearon, 1998
- Behavioral Treatment Team for Substance Abuse in Schizophrenia
- education
- behavioral skills training (with strong emphasis on behavioral rehearsal)
- small group format
- financial contingencies for clean urines

Limiting Factors

- 'negative symptoms' characteristic of schizophrenia (avolitional, amotivational, withdrawal, lack of social and vocational skills, diminished responsiveness to social reinforcers)
- cognitive deficits (inability to focus, intrusive thoughts, difficulty guiding behavior via cognitive mediators)

Working with Chronic Patients

- Keep it simple
- clear, straightforward feedback
- more directive advice
- concrete listing of pros and cons
- lots of practice
- shaping
- appropriate expectations
- harm avoidance model

Behavioral Treatment for Substance Abuse in Schizophrenia (BTSAS)

- Bellack, Gearon and Alexander (NIDA)
- Motivational Interviewing
- Urinalysis contingency
- Social Skills training
- Education and Coping skills training
- Relapse prevention

BTSAS: Motivational Interviewing Component

- Review patterns of use
- Identify negative consequences
- Identify substance use reduction goals
- Identify obstacles to attaining goals
- Behavioral contracting

BTSAS:Urinalysis Contingency

- Weekly urinalyses
- small cash rewards and social reinforcement
- role plays with patients who test positive
- setting new goals

BTSAS:Social Skills Training

- Conversation skills
- Refusal skills
- self-talk

BTSAS: Education and Coping Skills

- Positive and negative aspects of using
- Biological basis of schizophrenia and neuroleptic drugs
- drugs, alcohol and schizophrenia
- High risk situations and avoidance coping strategies
- HIV and STD prevention strategies

Relapse Prevention

- High risk situations
- dealing with lapses, keeping these from becoming full scale relapses
- coping with negative affect
- money management skills